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THE
TREATMENT OF APOPLEXY.

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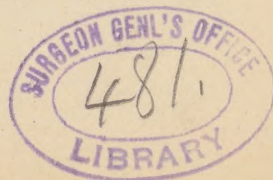
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NOTWITHSTANDING the generally accepted views that but little can be done in the way of relief for a case of apoplexy, I believe that proper measures instituted promptly will do much to lighten the subsequent disabilities. Even preventive treatment is of considerable use, but unfortunately the lesions that predispose to cerebral hæmorrhage escape recognition so frequently, that but little is ever done for the patient in this respect.

It is pretty well recognized that apoplectic seizures can only occur in the presence of vascular degeneration. In all patients in whom this condition is likely to exist, all influences which serve to increase intra-arterial tension must be avoided. The most frequently observed pathological condition of the vessels producing apoplexy is miliary aneurisms. So far as we know, there is no known measure aside from such general ones as tend to maintain the normal standard of health, that will prevent their progress. Their rupture is only a question of time. Their diagnosis is entirely out of the question. Next to miliary aneurisms in frequency as a cause of intra-cerebral hæmorrhage is atheromatous changes of the bloodvessels. Here we depend upon the condition of the radial artery and the age of the patient as a means of diagnosis. This condition is likewise unpreventable, as it is one of the changes incident to advancing years. In young adults, practically the only cause of apoplexy is syphilitic degeneration of the arteries. This of course may be obviated by efficient treatment of the syphilitic diathesis.

Certain diseases of the kidneys act in a twofold manner to produce apoplexy. In the first place, they are not infrequently productive of vascular disease, and in the second, they are often associated with



high arterial tension. Their proper treatment is practically one which lessens the chances of subsequent cerebral hæmorrhage.

Abstinence from meat diet and all alcoholic beverages, moderate indulgence in eating, a quiet life, the free drinking of water, the avoidance of exciting emotions, and the use of remedies like *glonoin*, *arsenic*, *arsenic iod.*, *phosphorus*, *belladonna*, and *nux vomica* are simply invaluable.

The treatment of the seizure itself is usually not very satisfactory, in that some permanent damage nearly always results, and yet I am satisfied that much may be done to alleviate the symptoms and render these later phenomena of apoplexy less disabling. In the first place absolute rest is of the highest importance. It has been claimed by some authorities that the apoplectic attack coming on very suddenly, that all damage is done in an instant. This is a mistake. One not infrequently meets with cases in which the symptoms are an hour or two, and even longer in developing. Often under these circumstances patients are encouraged by their friends to walk around, to throw their bad feelings off; most pernicious advice truly. The rest should be so absolute as to avoid even the making of passive movements.

Attention to the posture with the patient recumbent is not to be neglected. When stertor is a prominent symptom, the patient should be placed on his side. The effect of this change is sometimes wonderful. The loud snoring respiration ceases, the congested face pales, and the arterial tension diminishes at once.

The clothing should be loosened, and the head should be so placed as to avoid flexion of the neck, thus doing away with all obstruction to the return flow of blood from the brain.

When collapse is not present, the application of ice to the head has a beneficial effect, as it serves to excite contraction of the cerebral vessels. When collapse is present, mustard plasters to the nape of the neck have been recommended by Gowers as of value in inducing reflex contraction of the arteries.

The lancet as a means of reducing arterial tension has been very properly abandoned by all intelligent physicians in the treatment of apoplexy. We may, however, employ the device first formally suggested by Dr. Dawbarn, of New York, to "bleed the patient into his veins," so to speak. As soon as possible the physician should cut off the return circulation from the lower extremities. This is done by the application of an Esmarch bandage, a tourniquet, or Spanish windlass to one or more of the extremities, and as near the

trunk as possible. The apparatus should be made sufficiently tight to obstruct the return flow through the veins pretty thoroughly, but not so much so as to interfere with the arterial flow. Experimental evidence shows pretty clearly that this procedure lowers arterial tension, and favors the cessation of internal hæmorrhages. The pressure should be kept up for about an hour. Then the blood should be permitted to enter the general circulation very slowly. The only objection to Dawbarn's suggestion is that of possible danger in the hands of those who are unskilled and who lack judgment. Persons of that kind should never undertake the treatment of a human being, no matter how mild his ills ; consequently the objection fails to have weight.

There are cases, many of them indeed, in which all our best-directed efforts fail of relief, and deep and long-lasting coma supervenes. These must be treated on general principles. The bedding requires the most careful attention, owing to the danger from bed-sores ; in extreme cases the water-bed is advisable, if not absolutely necessary. Extreme cleanliness must be enjoined.

When the extremities are cold, hot water bottles should be used. They should be applied with the greatest care, however. Owing to the patient's helpless condition the liability to produce burns is great, and a burn in a hemiplegic patient is a serious matter, for local nutrition is poor and the danger of sloughing correspondingly great.

In all cases stimulation by alcohol is bad practice.

Should there be a very high temperature (105° F. or higher) I should certainly have recourse to the ice pack. I have used it in other brain affections with high temperature with excellent results, though as yet not in apoplexy.

As to medicines, if in the beginning there is an excited condition of the circulation, *aconite* should be administered. It will almost certainly have a beneficial effect.

If the cerebral congestion be a prominent symptom *belladonna* should be thought of, especially with the characteristic circulatory disturbances of that remedy.

Glonoïn I would advise in cases in which the arterial tension is high and there is coexisting kidney disease. One drop of the first centesimal dilution should be given three times daily. As the administration of the drug is continued it may be given at shorter intervals until the patient is taking it every two or three hours.

Opium should be thought of in cases characterized by marked venous congestion. The profoundness of the stupor is not an indi-

cation for the drug, because that is dependent upon the severity of the case and therefore upon mechanical causes only. For this opium, or in fact any other drug, is powerless.

Arnica is the drug that should be administered after the acute symptoms have subsided to promote absorption of the effused blood.

For the subsequent paralyses *causticum* has done more good in my hands than any other remedy. It is of course impossible to say how much of the improvement in these cases is due to drug and how much to time, which is certainly an essential element in their cure and improvement.

Sulphur and *baryta carb.*, the latter especially in old people, have likewise been recommended as remedies that will promote the absorption of the clot.

Attention to the kidneys is always an important matter. Whenever there is any albuminuria or excess of uric acid I advise the use of Londonderry or Buffalo lithia water, preferably the former carbonated.

When the subject of cerebral surgery was first broached it was thought that a possible remedy for apoplectic extravasations had been announced. Unfortunately, this is not so, for it takes but a little thought to see at once that surgical interference in the vast majority of cases is worse than useless, probably harmful. When the symptoms are such as to point without question to a sub- or extra-dural hæmorrhage, much may be accomplished, providing, of course, that the cerebral arteries are not too far advanced in their degeneration. When, on the other hand, the hæmorrhage is in the corpora striata, the effused blood cannot be liberated without seriously damaging important brain fibres.

Electricity is often proposed as a remedy in apoplectic paralysis. There is great danger that the pressure brought to bear by the family may lead to its use either too early in the case or in entirely unsuitable cases. I would advise that the patient be permitted to enjoy rest without electrical interference. In the course of a month or so the application of galvanism to the head may prove useful by promoting absorption of the clot. Galvanization of the contracted muscles and faradism of their opponents have been recommended when the stage of late rigidity has come on. I have had very little success with these measures, and have ceased encouraging patients to resort to them. I have decidedly more confidence in the applications to the head.

Horsley has recommended ligation of the common carotid on the

side of the lesion as a means of stopping the internal hæmorrhage. There can be no doubt, if we are to judge from experimental evidence, of the efficacy of this procedure, but the operation is of such a severe character, and requires so many precautions to render it safe, that by the time it has been performed the hæmorrhage has ceased spontaneously. Carotid compression is probably as efficient.

Something can be done in the late stages of post-apoplectic paralysis by properly directed gymnastics of the paralyzed parts. The aim should be to call the healthy side of the brain into play to help the injured one. This may be done by directing similar movements to be performed on both sides of the body simultaneously. It is astonishing how much better are the movements of the paralyzed extremity when thus performed than when the limb is made to move by itself. This is a field that has not been thoroughly developed, but I think it one of some promise.

The apoplectic patient is in every instance a disabled one. Though he should be so fortunate as to recover without a semblance of paralysis he is still largely incapacitated for his former labors. Ever afterwards he should live, as far as possible, quietly and abstemiously, enjoying life as best he may.

